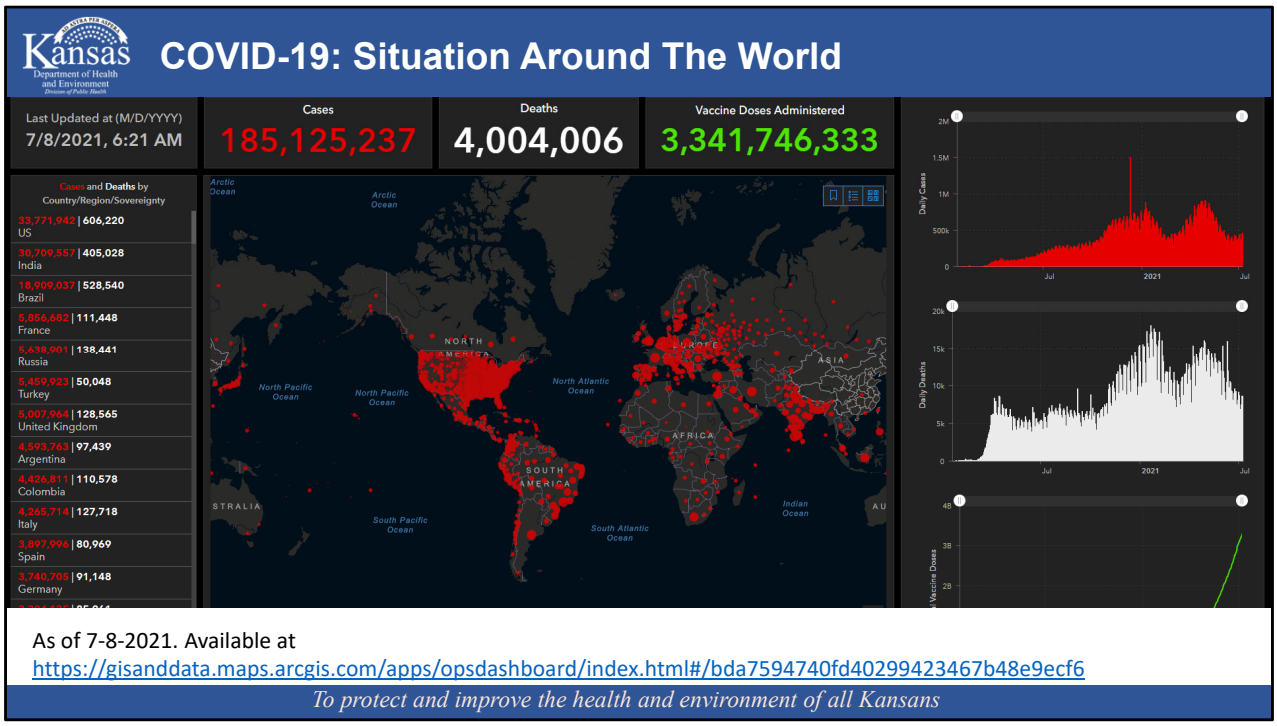

Kansas
Department of Health and Environment
Division of Public Health
Lee A. Norman, MD, MHS, MBA, Secretary
COVID-19 Webinar Series Welcome
July 8, 2021


Kansas
Department of Health and Environment
Division of Public Health
Farah S. Ahmed, MPH, PhD, State Epidemiologist
COVID-19 Situation Update
July 8, 2021



As of 7-8-2021. Available at
https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6

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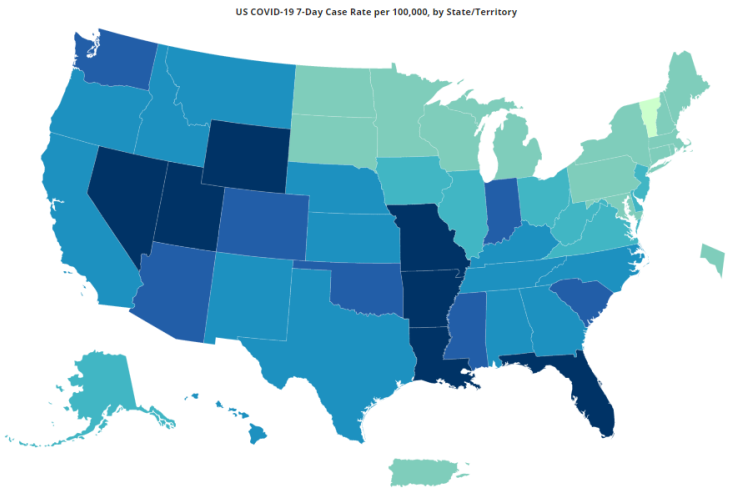
Global Map: https://www.cdc.gov/coronavirus/2019-ncov/locations-confirmed-cases.html.

Last week, we had 182.1 million cases around the world and a bit over 3.9 million deaths.

This week, there are 185,125,237 cases and we have 4,004,006 deaths around the world.

COVID-19: Situation in the US

- Total cases: 33,582,352



As of 7-8-2021. Available at https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days

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Last week in the US:

Total cases: 33,485,433 (over 33.4 million)

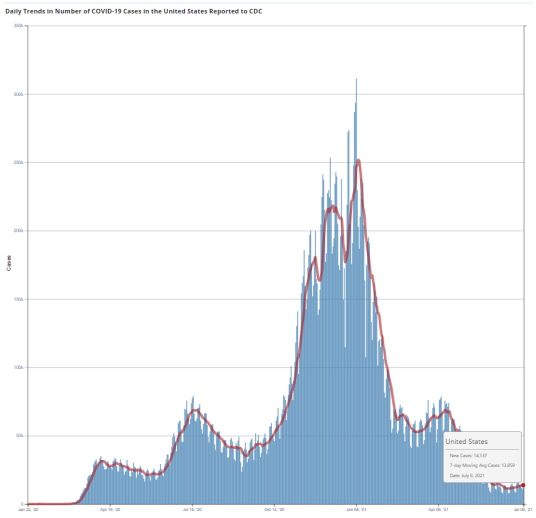
As of yesterday

This week:

Total cases: 33,582,352

And you can see from the map of the 7 day case rate that KS is doing okay compared to most of our surrounding states.

COVID-19: Situation in the US



As of 7-8-2021. Available at https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendscases

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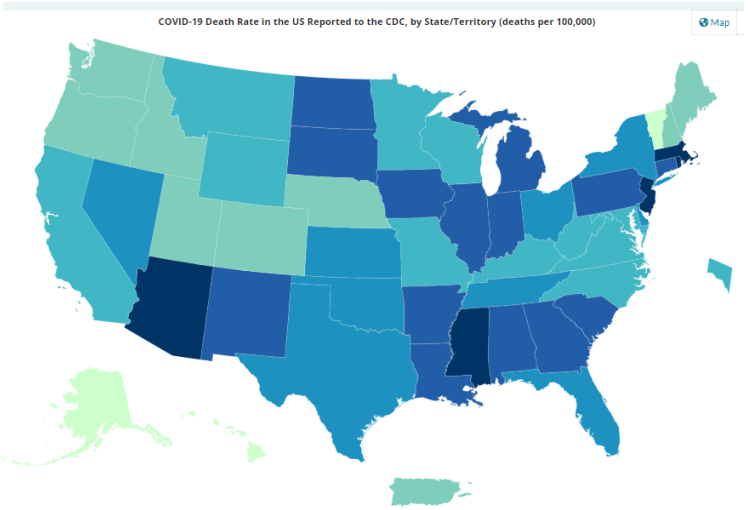
In the US, you can see that we are averaging about 13,800 new cases each day according to the 7-day average. That is up from 12,600 from the previous week.

COVID-19: Situation in the US

- Total deaths: 603,656



As of 7-8-2021. Available at https://covid.cdc.gov/covid-data-tracker/#cases_deathsper100k

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Last week in the US:

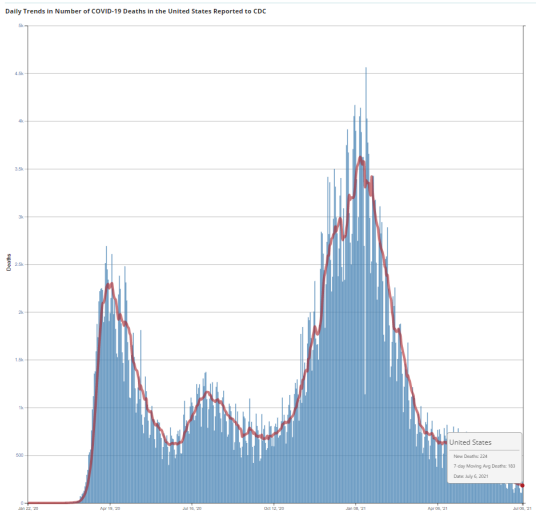
Total deaths: 602,133 (a little over 602,000)

As of yesterday

This week:

Total deaths: 603,656

COVID-19: Situation in the US



As of 7-8-2021. Available at https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendscases

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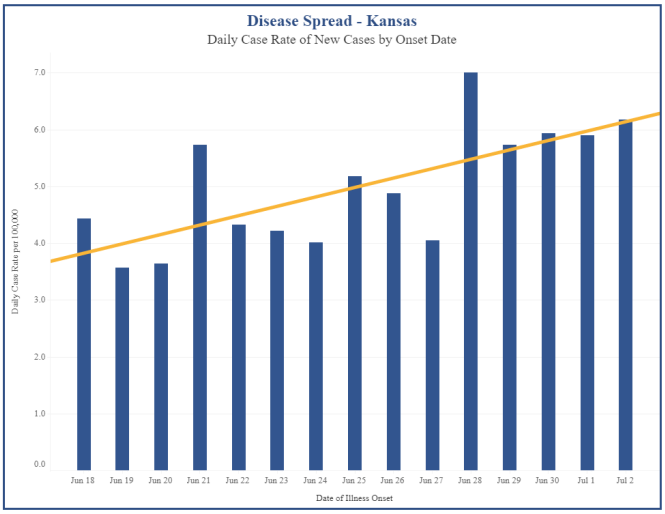
The 7-day moving average daily death trend in the United States is about 183 deaths per day which is down from 280 last week.

COVID-19: Situation in Kansas



Available at: https://www.coronavirus.kdheks.gov/160/COVID-19-in-Kansas

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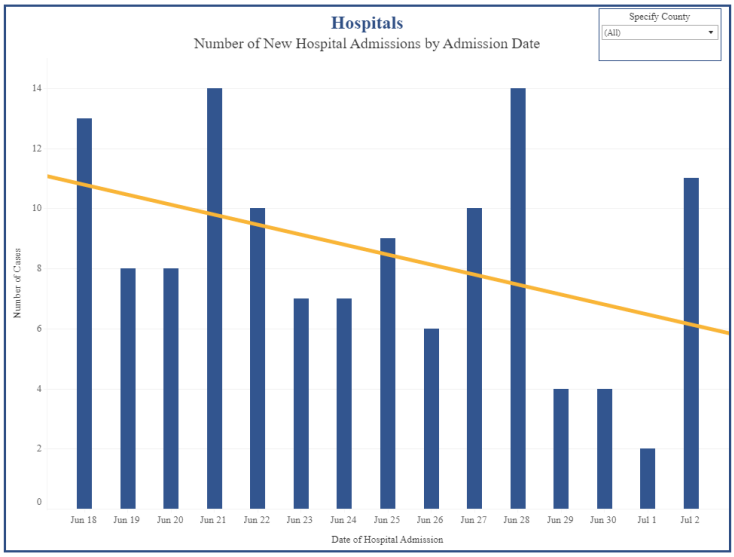
Moving on to KS specific data. For our first Disease Spread metric, which is the daily rate of new cases, the trend line last week was slightly increasing last week and it is pretty sharply increasing this week.

COVID-19: Situation in Kansas



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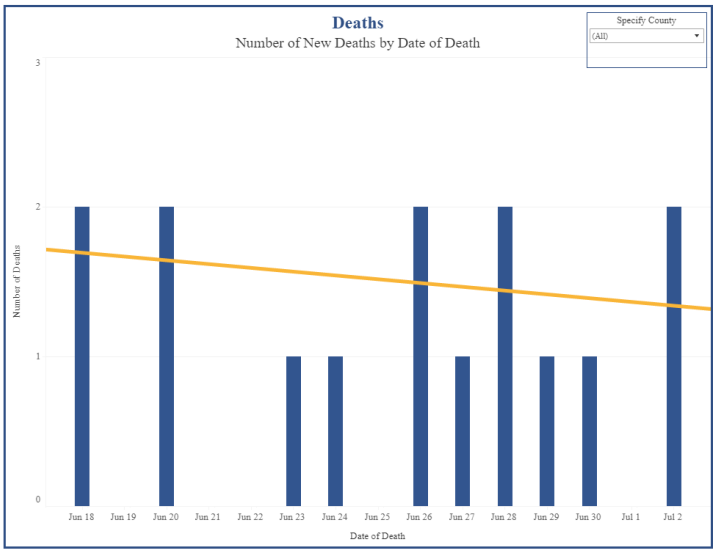
For hospitalizations, the trend last week was decreasing last week and that continues this week. As a reminder, this is information gathered during the public health interview of cases and represents hospitalizations at the time of interview. We will take a look at some hospital reported data in a bit to see what that looks like.

COVID-19: Situation in Kansas



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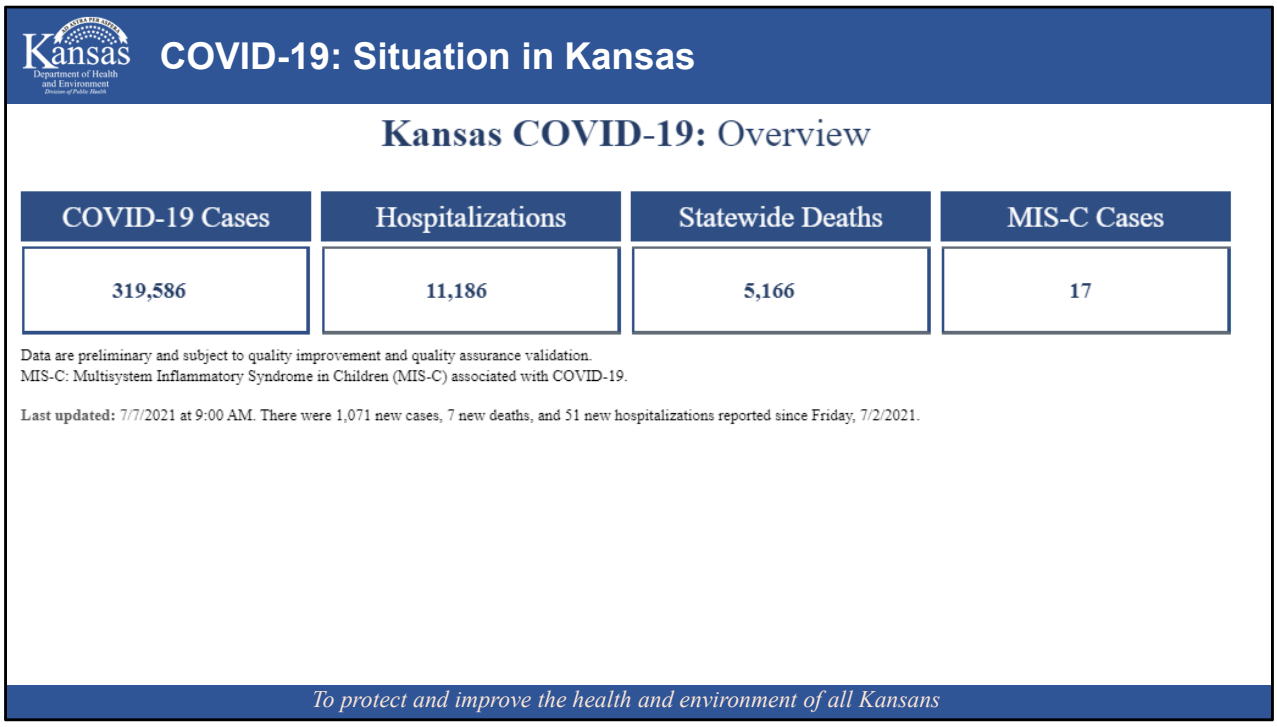
And for deaths, last week the trend was pretty flat and it is slightly decreasing this week.



As of yesterday, we had 319,586 cases (which is an increase of 1,480 cases since last week) and 5,166 deaths statewide (that's an increase of 10 deaths since last week).

There were 1,071 new cases and 7 new deaths reported between Friday 7/2/2021 and Wednesday 7/7/2021. Monday was a holiday and the dashboard wasn't updated.

COVID-19: Situation in Kansas: Outbreaks

Last updated: 7/7/2021 at 9:00 AM. Cluster Summary data is updated every Wednesday.

Active COVID-19 Clusters			
Clusters	Cases	Hospitalizations	Deaths
45	298	21	7

All COVID-19 Clusters			
Clusters	Cases	Hospitalizations	Deaths
2,188	40,066	2,029	2,167

- 40,066 outbreak-related cases/319,586 cases (12.5%)
- 2,029 outbreak-related hospitalizations/11,186 total hospitalizations (18.1%)
- 2,167 outbreak-related deaths/5,166 total deaths (41.9%)

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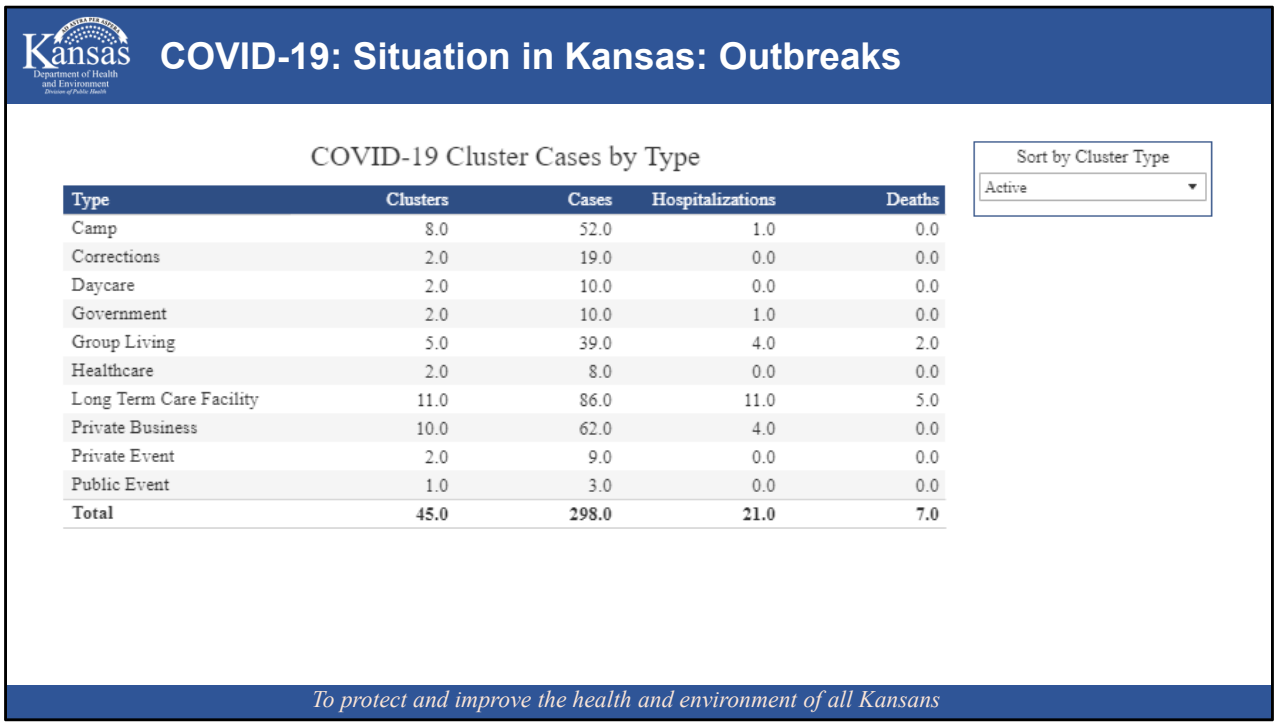
Moving on to outbreaks:

As of late Tuesday night, we had 2188 outbreaks across the state; This week we have 45 active clusters which is a big jump from the 26 last week.

Our percentage of outbreak related cases is 12.5%, outbreak-related hospitalizations is about 18.1% and outbreak-related deaths is about 41.9%.



Type	Clusters	Cases	Hospitalizations	Deaths
Camp	8.0	52.0	1.0	0.0
Corrections	2.0	19.0	0.0	0.0
Daycare	2.0	10.0	0.0	0.0
Government	2.0	10.0	1.0	0.0
Group Living	5.0	39.0	4.0	2.0
Healthcare	2.0	8.0	0.0	0.0
Long Term Care Facility	11.0	86.0	11.0	5.0
Private Business	10.0	62.0	4.0	0.0
Private Event	2.0	9.0	0.0	0.0
Public Event	1.0	3.0	0.0	0.0
Total	**45.0**	**298.0**	**21.0**	**7.0**

We currently have 8 active outbreaks in camps, which is up from just 1 last week. We have 11 active outbreaks in LTCFs (which is up slightly from 9 last week). We also have 5 outbreaks in group living settings and 10 in private businesses.

Don't forget, if you are interested in seeing the list of named locations with 5 or more cases within the last 14 days, you can go to the dashboard.

COVID-19: New Resource

This table is updated several times a week, as needed. Last updated July 7, 2021 with EDC data submitted July 6, 2021

Parent Company	Cruise Line	No Sail Order Response Plan Status	Ship Name	Ship Status
Bahamas Paradise Cruise Line	Bahamas Paradise Cruise Line	Complete and accurate with signed acknowledgement	Grand Classica	Red
Carnival Corporation	Carnival Cruise Lines, Inc.	Complete and accurate with signed acknowledgement	Carnival Breeze	Orange
			Carnival Conquest	Green
			Carnival Ecstasy	Green
			Carnival Elation	Green
			Carnival Freedom	Orange
			Carnival Horizon	Orange
			Carnival Liberty	Orange
			Carnival Mardi Gras	Orange

Available at: https://www.cdc.gov/coronavirus/2019-ncov/travelers/crew-disembarkations-commercial-travel.html

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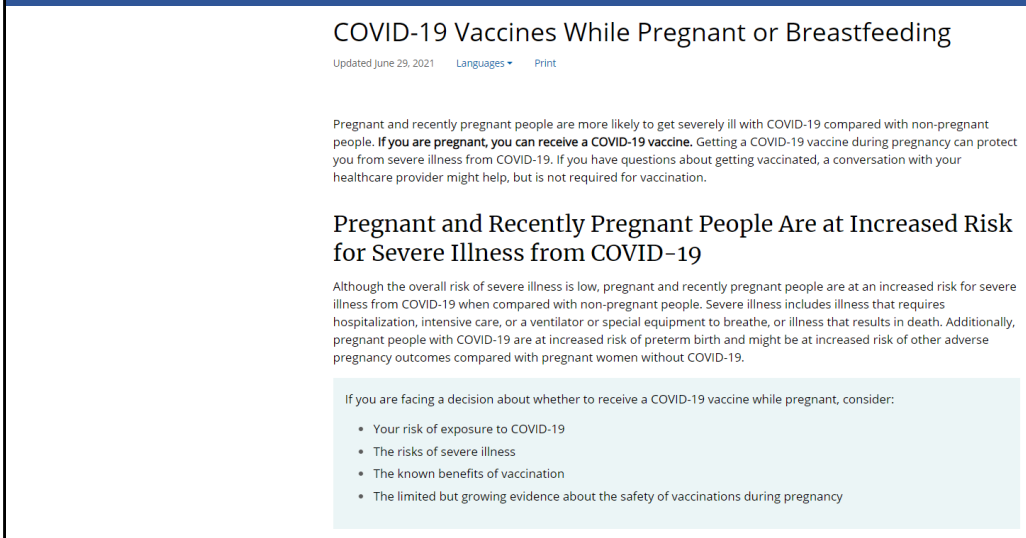
CDC implemented the COVID-19 color-coding system for cruise ships to mitigate transmission of COVID-19 onboard. Onboard preventative measures are recommended or required based on ship color status.

COVID-19: New Resource



COVID-19 Vaccines While Pregnant or Breastfeeding

Updated June 29, 2021 Languages Print

Pregnant and recently pregnant people are more likely to get severely ill with COVID-19 compared with non-pregnant people. **If you are pregnant, you can receive a COVID-19 vaccine.** Getting a COVID-19 vaccine during pregnancy can protect you from severe illness from COVID-19. If you have questions about getting vaccinated, a conversation with your healthcare provider might help, but is not required for vaccination.

Pregnant and Recently Pregnant People Are at Increased Risk for Severe Illness from COVID-19

Although the overall risk of severe illness is low, pregnant and recently pregnant people are at an increased risk for severe illness from COVID-19 when compared with non-pregnant people. Severe illness includes illness that requires hospitalization, intensive care, or a ventilator or special equipment to breathe, or illness that results in death. Additionally, pregnant people with COVID-19 are at increased risk of preterm birth and might be at increased risk of other adverse pregnancy outcomes compared with pregnant women without COVID-19.

If you are facing a decision about whether to receive a COVID-19 vaccine while pregnant, consider:

- Your risk of exposure to COVID-19
- The risks of severe illness
- The known benefits of vaccination
- The limited but growing evidence about the safety of vaccinations during pregnancy

Available at: https://www.cdc.gov/coronavirus/2019-ncov/travelers/crew-disembarkations-commercial-travel.html

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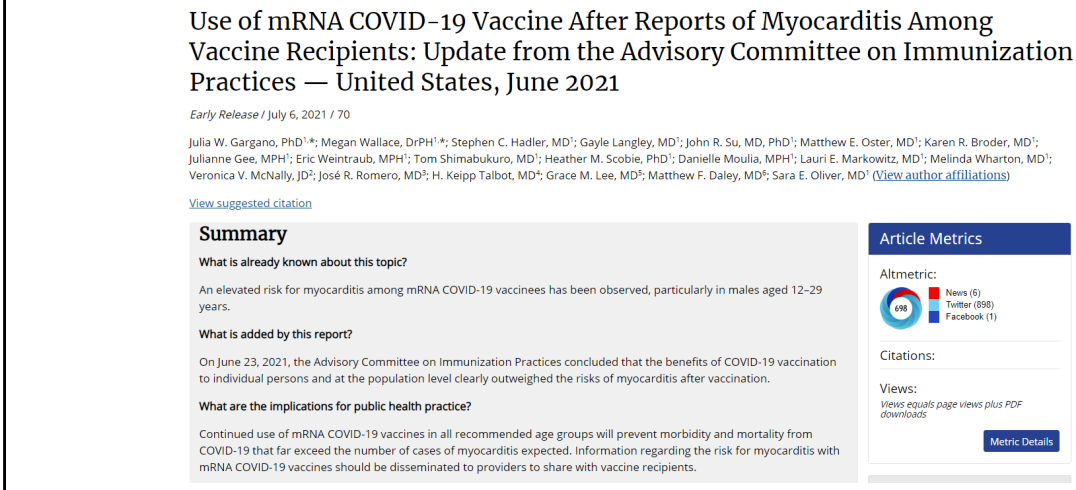
The June 29, 2021 update provides information on benefits and side effects related to COVID-19 vaccines, and available data on vaccination among people who are pregnant, those who are breastfeeding, and those would like to have a baby.

There is currently no evidence that any vaccines, including COVID-19 vaccines, cause female or male fertility problems—problems getting pregnant. CDC does not recommend routine pregnancy testing before COVID-19 vaccination. If you are trying to become pregnant, you do not need to avoid pregnancy after receiving a COVID-19 vaccine.

COVID-19: New Literature



Use of mRNA COVID-19 Vaccine After Reports of Myocarditis Among Vaccine Recipients: Update from the Advisory Committee on Immunization Practices — United States, June 2021

Early Release / July 6, 2021 / 70

Julia W. Gargano, PhD[1,*]; Megan Wallace, DrPH[1,*]; Stephen C. Hadler, MD[1]; Gayle Langley, MD[1]; John R. Su, MD, PhD[1]; Matthew E. Oster, MD[1]; Karen R. Broder, MD[1]; Julianne Gee, MPH[1]; Eric Weintraub, MPH[1]; Tom Shimabukuro, MD[1]; Heather M. Scobie, PhD[1]; Danielle Moulia, MPH[1]; Lauri E. Markowitz, MD[1]; Melinda Wharton, MD[1]; Veronica V. McNally, JD[2]; José R. Romero, MD[3]; H. Keipp Talbot, MD[4]; Grace M. Lee, MD[5]; Matthew F. Daley, MD[6]; Sara E. Oliver, MD[1] (View author affiliations)

View suggested citation

Summary

What is already known about this topic?

An elevated risk for myocarditis among mRNA COVID-19 vaccinees has been observed, particularly in males aged 12–29 years.

What is added by this report?

On June 23, 2021, the Advisory Committee on Immunization Practices concluded that the benefits of COVID-19 vaccination to individual persons and at the population level clearly outweighed the risks of myocarditis after vaccination.

What are the implications for public health practice?

Continued use of mRNA COVID-19 vaccines in all recommended age groups will prevent morbidity and mortality from COVID-19 that far exceed the number of cases of myocarditis expected. Information regarding the risk for myocarditis with mRNA COVID-19 vaccines should be disseminated to providers to share with vaccine recipients.

Article Metrics

Altmetric:

698

News (6)
Twitter (898)
Facebook (1)

Citations:

Views:

Views equals page views plus PDF downloads

Metric Details

Available at: https://www.cdc.gov/mmwr/volumes/70/wr/mm7027e2.htm?s_cid=mm7027e2_w

In May 2021, FDA expanded the EUA for the Pfizer-BioNTech COVID-19 vaccine to include adolescents aged 12–15 years; ACIP recommends that all persons aged ≥12 years receive a COVID-19 vaccine. After reports of myocarditis and pericarditis in mRNA vaccine recipients,¶ which predominantly occurred in young males after the second dose, an ACIP meeting was rapidly convened to review reported cases of myocarditis and pericarditis and discuss the benefits and risks of mRNA COVID-19 vaccination in the United States.

On June 23, 2021, the Advisory Committee on Immunization Practices concluded that the benefits of COVID-19 vaccination to individual persons and at the population level clearly outweighed the risks of myocarditis after vaccination. The EUA has been modified to include information on myocarditis after receipt of mRNA COVID-19 vaccines. The EUA fact sheets should be provided before vaccination; in addition, CDC has developed patient and provider education materials about the possibility of myocarditis and symptoms of concern, to ensure prompt recognition and management of myocarditis.

COVID-19: New Literature

Annals of Epidemiology
Available online 20 June 2021
In Press, Journal Pre-proof

Trends in the distribution of COVID-19 deaths by age and race/ethnicity — United States, April 4–December 26, 2020

Lauren M. Rossen PhD [1], Jeremy A.W. Gold MD [2], Farida B. Ahmad MPH [1], Paul D. Sutton PhD [1], Amy M. Branum PhD [1]

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Key words

Mortality; Coronavirus 2019; SARS-CoV-2; Disparities; National Vital Statistics System

Introduction

The coronavirus disease 2019 (COVID-19) pandemic has disproportionately affected racial and ethnic minority groups.1, 2, 3, 4, 5 COVID-19 infection and mortality rates are higher among Hispanic/Latino, non-Hispanic Black, and non-Hispanic

Available at: https://www.sciencedirect.com/science/article/pii/S104727972100154X?via%3Dihub

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Key findings:

The largest percentage of COVID-19 deaths from April through October occurred in older persons aged ≥ 85 years among both the non-Hispanic White and non-Hispanic Asian populations (Figure).

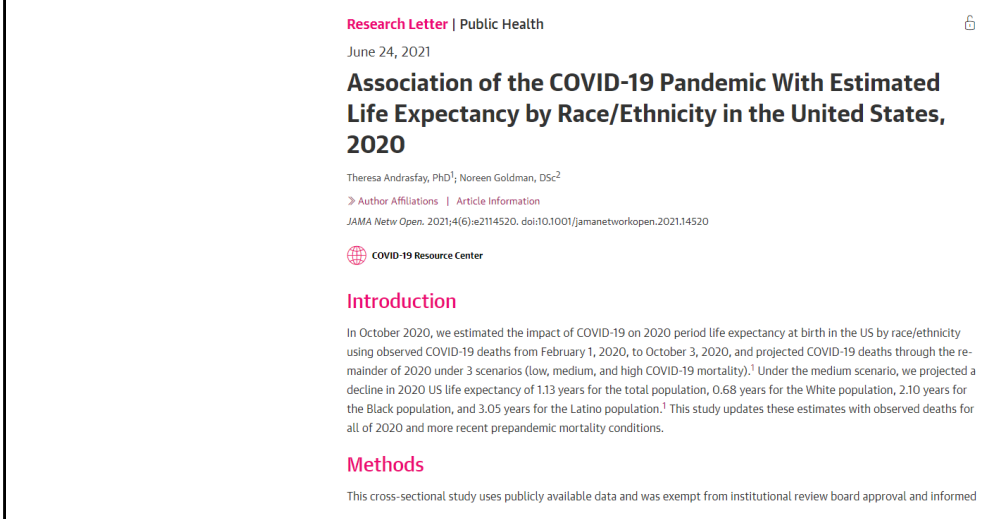
Compared with the White population, the age distributions of COVID-19 deaths among non-Hispanic NHOPI and other racial/ethnic groups, were younger (Figure).

The percentage of COVID-19 deaths declined in all age groups 25 and older for non-Hispanic Black persons since April and, since late July, for Hispanic persons.

Methods: Using data from the National Vital Statistics System, the percentage distribution of 363,087 US COVID-19 deaths from April 4 through December 26, 2020 was calculated by age group (<25, 25–44, 45–64, 65–74, 75–84, and ≥85 years) within race/ethnicity groups (Hispanic, non-Hispanic White, non-Hispanic Black, non-Hispanic Asian, non-Hispanic AI/AN, non-Hispanic Native Hawaiian or other Pacific Islander [NHOPI], other). ***Limitations***: COVID-19 deaths may be underestimated by race/ethnicity due to differential reporting on death certifications; small number of deaths in some race/ethnic groups.

Implications: Prevention efforts need to focus on highly impacted older age groups and also on Hispanic/Latino, non-Hispanic Black, non-Hispanic AI/AN, and non-Hispanic NHOPI populations, where a majority of COVID-19 deaths were among persons aged <75 years.

COVID-19: New Literature



Research Letter | Public Health

June 24, 2021

Association of the COVID-19 Pandemic With Estimated Life Expectancy by Race/Ethnicity in the United States, 2020

Theresa Andrasfay, PhD[1]; Noreen Goldman, DSc[2]

Author Affiliations | Article Information

JAMA Netw Open. 2021;4(6):e2114520. doi:10.1001/jamanetworkopen.2021.14520

COVID-19 Resource Center

Introduction

In October 2020, we estimated the impact of COVID-19 on 2020 period life expectancy at birth in the US by race/ethnicity using observed COVID-19 deaths from February 1, 2020, to October 3, 2020, and projected COVID-19 deaths through the remainder of 2020 under 3 scenarios (low, medium, and high COVID-19 mortality).[1] Under the medium scenario, we projected a decline in 2020 US life expectancy of 1.13 years for the total population, 0.68 years for the White population, 2.10 years for the Black population, and 3.05 years for the Latino population.[1] This study updates these estimates with observed deaths for all of 2020 and more recent prepandemic mortality conditions.

Methods

This cross-sectional study uses publicly available data and was exempt from institutional review board approval and informed

Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2781320?resultClick=1

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Key findings:

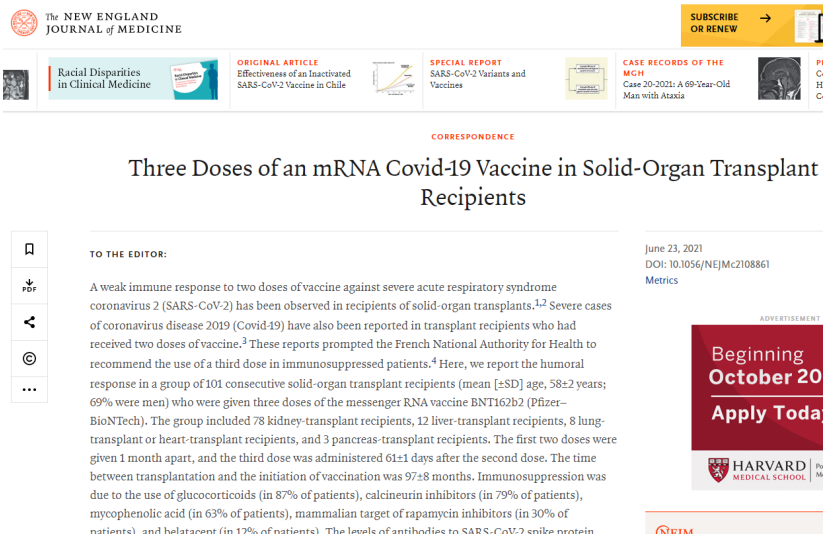
Updated life expectancy estimates show that COVID-19 reduced overall US life expectancy from 78.74 to 77.43 years (Figure).

Compared with the White population (0.94 years), reductions were 3.2 times larger for the Latino population (3.03 years) and 2 times larger for the Black population (1.90 years) (Figure).

Methods: Cross-sectional study using 380,868 COVID-19 deaths in 2020 to estimate changes in life expectancy associated with COVID-19 for the total US population, non-Latino White, non-Latino Black, and Latino populations. ***Limitations***: COVID-19 deaths may be underestimated by race/ethnicity due to differential reporting on death certificates.

Implications: Disproportionate declines in life expectancy among Latino and Black populations may stem from social and economic inequities that are associated with higher exposure to infection, poorer care once infected and thus higher fatality among those infected.

COVID-19: New Literature



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CASE RECORDS OF THE MGH
Case 20-2021: A 69-Year-Old Man with Ataxia

CORRESPONDENCE

Three Doses of an mRNA Covid-19 Vaccine in Solid-Organ Transplant Recipients

TO THE EDITOR:

A weak immune response to two doses of vaccine against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has been observed in recipients of solid-organ transplants.[1,2] Severe cases of coronavirus disease 2019 (Covid-19) have also been reported in transplant recipients who had received two doses of vaccine.[3] These reports prompted the French National Authority for Health to recommend the use of a third dose in immunosuppressed patients.[4] Here, we report the humoral response in a group of 101 consecutive solid-organ transplant recipients (mean [±SD] age, 58±2 years; 69% were men) who were given three doses of the messenger RNA vaccine BNT162b2 (Pfizer–BioNTech). The group included 78 kidney-transplant recipients, 12 liver-transplant recipients, 8 lung-transplant or heart-transplant recipients, and 3 pancreas-transplant recipients. The first two doses were given 1 month apart, and the third dose was administered 61±1 days after the second dose. The time between transplantation and the initiation of vaccination was 97±8 months. Immunosuppression was due to the use of glucocorticoids (in 87% of patients), calcineurin inhibitors (in 79% of patients), mycophenolic acid (in 63% of patients), mammalian target of rapamycin inhibitors (in 30% of patients), and belatacept (in 12% of patients). The levels of antibodies to SARS-CoV-2 spike protein

June 23, 2021
DOI: 10.1056/NEJMc2108861
Metrics

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The next few pieces of literature are being presented to you for your information. There are a lot of questions about booster doses, booster doses for certain susceptible populations, what are the effects of mixing and matching vaccine, etc. I have found a few research projects looking at these questions and am presenting articles today. This does not mean that KDHE is making any new recommendation about how vaccines should be administered. But since these questions come up a lot, I am including some information on scientific studies here. I will continue to bring these to you as I find them.

Key findings:
Among solid-organ transplant recipients, the prevalence of anti-SARS-CoV-2 antibodies was:

- 0% (95% CI 0 to 4) of 101 patients before the 1st dose of BNT162b2 (Pfizer/BioNTech) (Figure).
- 4% (95% CI 1 to 10) of 101 patients before the 2nd dose (Figure).
- 40% (95% CI 31 to 51) of 99 patients before the 3rd dose (Figure).
- 68% (95% CI 58 to 77) of 99 patients 4 weeks after the 3rd dose (Figure).

No serious adverse events were reported after the 3rd dose, and no acute rejection episodes occurred.
Methods: In an anonymous retrospective study of solid-organ transplant recipients in France, 99 patients received a 3rd dose of BNT162b2 vaccine 61±1 days after the 2nd dose. Prevalence of anti-SARS-CoV-2 antibodies was assessed before the 3rd dose and 1 month afterward. Any adverse events, including rejection episodes, were recorded. ***Limitations***: Small sample size, unknown how antibody response correlates with protection from infection.
Implications: Immunogenicity to BNT162b2 is reduced among solid-organ transplant patients but increases with additional doses. Transplant recipients and their close contacts should be vaccinated against COVID-19, and transplant recipients should continue to take precautions (masking, distancing, avoiding crowds and poorly ventilated indoor spaces) to protect themselves against COVID-19, even after vaccination.

COVID-19: New Literature

Available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01420-3/fulltext

Key findings:

By day 14 post-heterologous COVID-19 vaccination:

SARS-CoV-2 receptor binding domain antibodies (anti-RBD) titers increased from 71.46 BAU/mL to 7,756.68 BAU/mL.

Trimeric spike protein antibody titers increased from 98.40 BAU/mL to 3,684.87 BAU/mL.

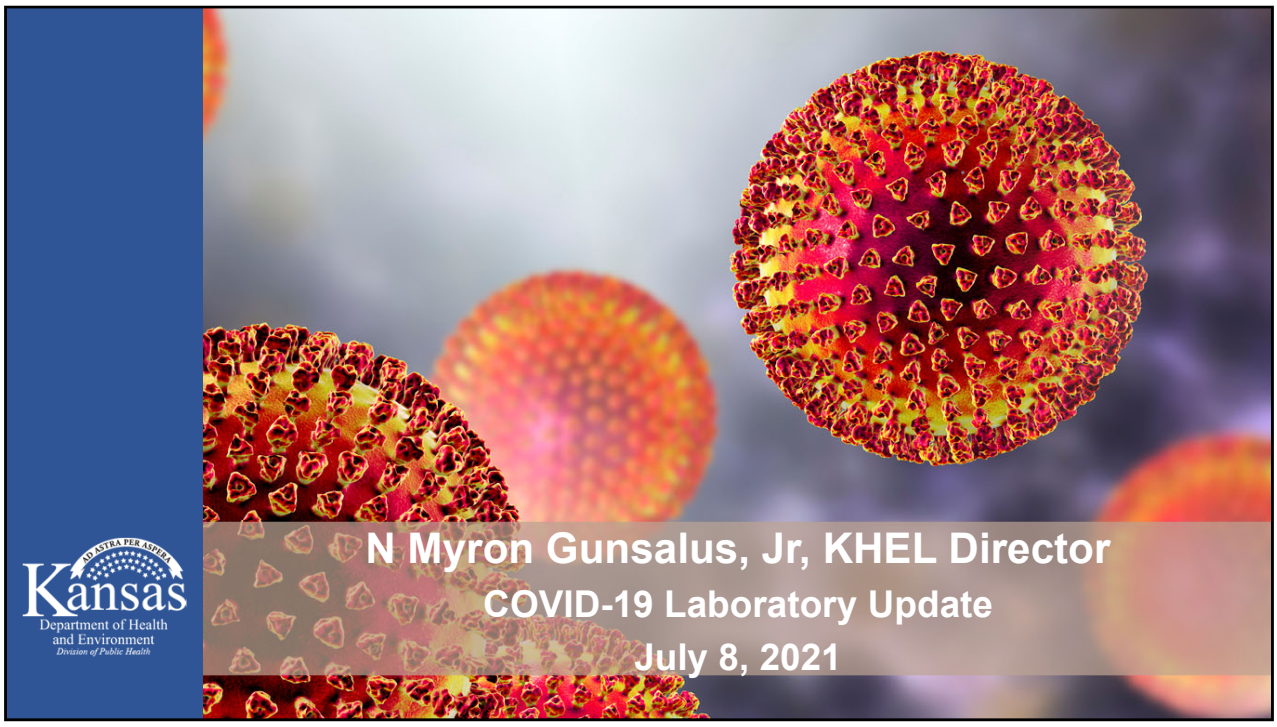
Neutralizing antibody capacity was high (NT_{50}>1:300 and <1:1,000) or very high (NT_{50}>1:1,000).

All humoral immune responses were significantly higher than those of the controls (p<0·0001) (Figure).

No serious adverse events were reported.

Methods: Phase 2, open-label, randomized, controlled trial conducted in 5 Spanish hospitals. Adults aged 18–60 years who received a prime ChAdOx1 (AstraZeneca/Oxford) dose 8–12 weeks prior to enrollment were randomly assigned (2:1) to receive either a single dose of BNT162b2 (Pfizer/BioNTech, n = 441) or no vaccine (control group, n = 222). Immune response and antibody neutralization capacity (n = 198) were determined up to 14 days after BNT162b2 dose. 7-day reactogenicity was also determined. ***Limitations***: No control group completing the homologous ChAdOx1 regimen.

Implications: The use of an mRNA vaccine as a 2nd dose in a heterologous scheme may increase the immune response obtained after an initial dose of ChAdOx1, without serious adverse events.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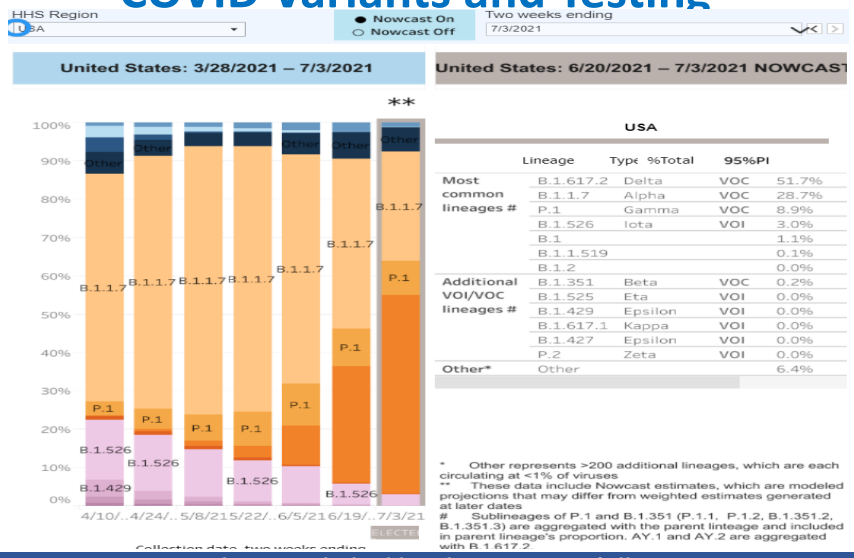
N Myron Gunsalus, Jr, KHEL Director
COVID-19 Laboratory Update
July 8, 2021

COVID-19: Laboratory Update

COVID Variants and Testing



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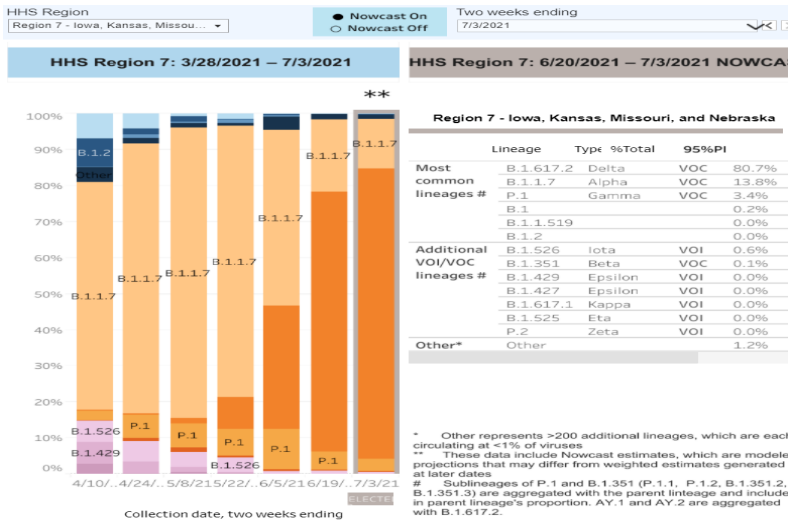
https://covid.cdc.gov/covid-data-tracker/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-updates%2Fvariant-surveillance%2Fgenomic-surveillance-dashboard.html#variant-proportions

This is the latest with prediction/now cast on to predict out. Significance is that P.1 and B.1.617.2 are growing significantly.

Kansas Department of Health and Environment

COVID-19: Laboratory Update

COVID Variants and Testing REGION 7



To protect and improve the health and environment of all Kansans

https://covid.cdc.gov/covid-data-tracker/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-updates%2Fvariant-surveillance%2Fgenomic-surveillance-dashboard.html#variant-proportions

CDC now has a new modeling program included called “Nowcast”. If you turn it on, as shown in this slide, it predicts the next 2 weeks of proportional data associated with the variants. You can use it for regional or US wide evaluations.

Keep in mind these are not absolute numbers but are proportional numbers and only relate to those sequences performed by CDC

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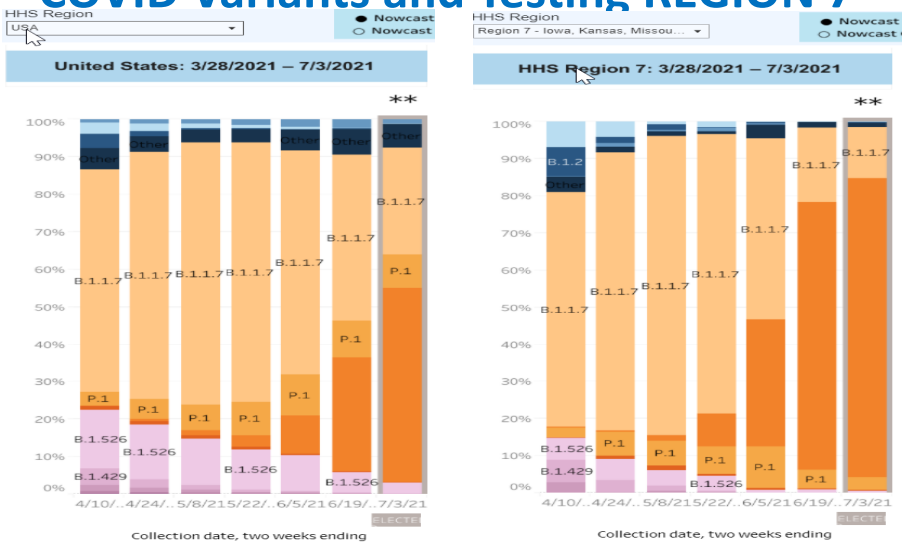

To protect and improve the health and environment of all Kansans

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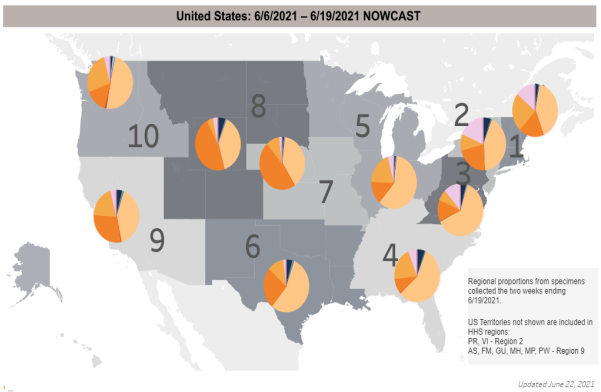
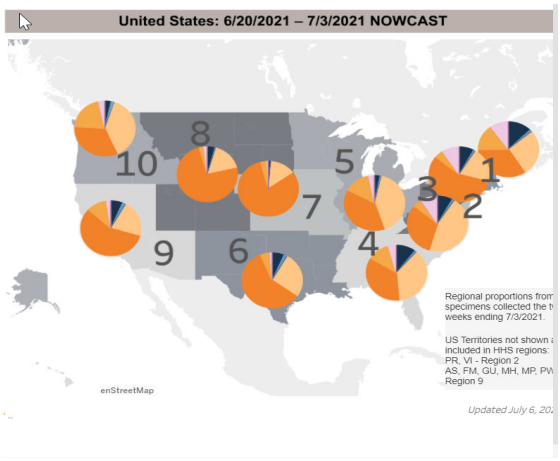
This is comparing USA vs Region 7

COVID-19: Laboratory Update

COVID Variants National View 6/19/21 vs 7/3/21





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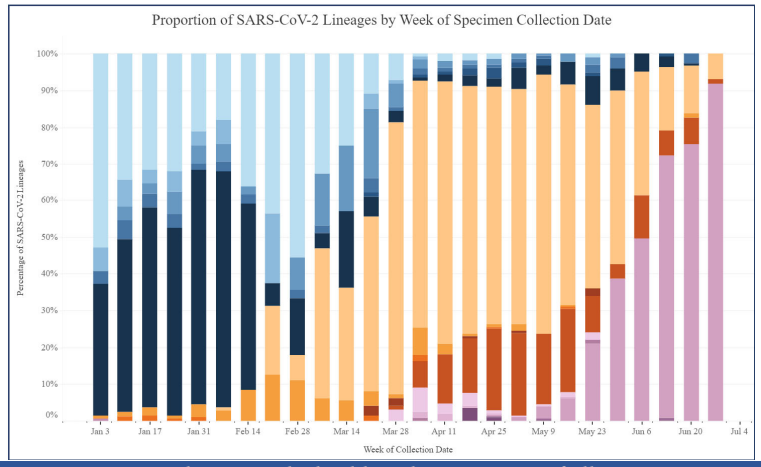
Kansas Department of Health and Environment

COVID-19: Laboratory Update

COVID Variants and Kansas Results



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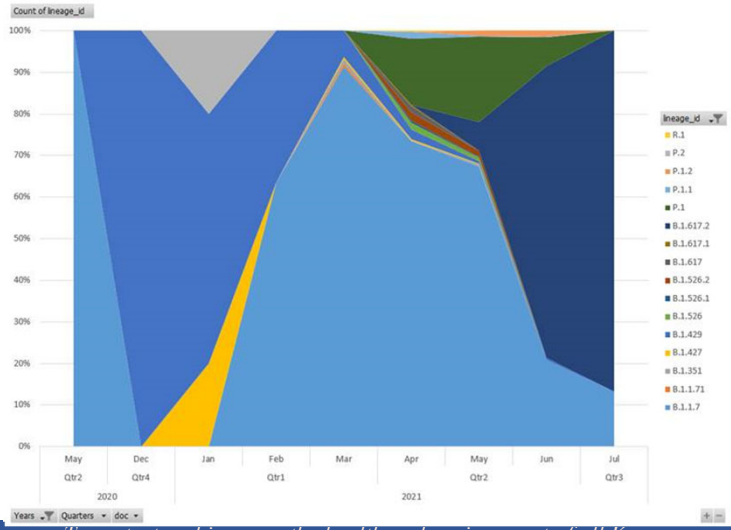
https://www.coronavirus.kdheks.gov/160/COVID-19-in-Kansas

The purple is the Delta, B.1.617.2 variant

COVID Variants and Kansas Results



Medium blue in Dec/January was mostly B.1.429 or California strain.

Large lighter blue in the middle is the B.1.1.7 (Alpha) strain

The Dark Blue that is currently ~80% of the total is B.1.617.2 or Delta Variant.

This graph is only VOC. But to give you a better idea we have only sequenced 7 non-VOCs since June 25th! 7 out of 377 in that time period are non-VOCs. So this graph is pretty accurate to the overall.
Y axis is percentage. B.1.1.7 (alpha) is dropping rapidly and being taken over by B.1.617.2 (delta).

If you are a lab that is running PCR for COVID detection, we are looking for ways to increase our statewide sequencing efforts

KHEL is looking to partner with labs to increase sequencing

Criteria

KHEL is asking labs to send any positive samples

However, KHEL is particularly interested in the following cases if all samples are not available

- **Examples:** Areas with high transmission (different age groups, geographic locations, severity), cases in areas with a significant increase of cases over a few weeks (not explained by relaxing public health measures), children in areas with increased incidence of pediatric disease, clusters of cases in people aged <60 without underlying conditions, cases in fully-vaccinated people or when re-infection is suspected

Samples with a CT value <30 are preferred, but higher CT values are OK if samples are of interest

Next steps

- To sign up for the program**, Contact KDHE.KHELINFO@KS.gov and include Subject Line: ATTENTION SEQUENCING**
  - Samples can be submitted through a form or lab online
  - For regular surveillance tell us how many PCR positives you typically have per week and could send.
- If there is a known case of reinfection or potential vaccine break through or "S-Deletion", then **contact KHEL for sequencing.**
- You **should not report PCR mutation screening to anyone as an identified variant.** Variants are only identified after confirmation whole genome sequencing
  - Send us extract if possible or a second sample in VTM

We will be providing guidance over next week to send all positive samples with a CT of less than 30 to KHEL for sequencing. We may or may not be able to do all of them, but this way we will start to get a better cross section of what is going on in the state.

We are currently working on a system that will also allow us to report back with the understanding that any sequencing data should not be used for patient care or diagnostic evaluation but can be used for public health response.

Please note: CMS has stated so far that sequencing results cannot be reported back to providers but only to Public Health. We will be working with Public Health staff regarding results of sequences but can only provide aggregate data back to any given laboratory

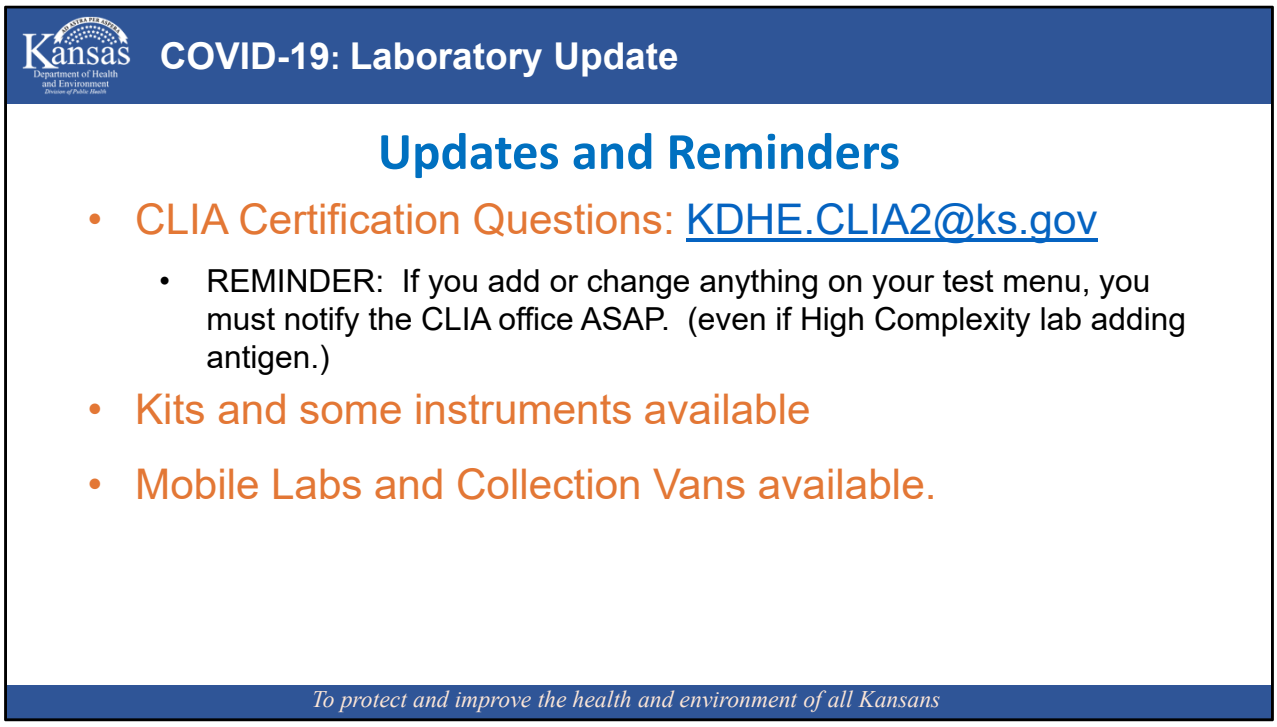
COVID-19: Laboratory Update---Courier Update

- It is live now. All counties should have a pickup happening 5 days per week.
- We do not want to delete any pickup site for at least the first month of full service.

Any questions regarding the courier service can be directed to:

Chad Yamashita

E-mail: Chad.Yamashita@ks.gov



We were notified by the CLIA certification office that there are a number of labs that have either Certificates of Waiver(COW) or other more complex certifications that brought on the antigen testing such as BinaxNow without notifying the CLIA office of the change in their test menu. All labs (including COWs) are required to notify CLIA of any addition or subtractions of tests or technologies offered in their test menu.

Adding COVID testing with the CLIA office does not issue a new certificate or put the name of the test on your certificate. It is a procedural requirement.


Kansas
Department of Health and Environment
Division of Public Health
Lacey Kennett, Preparedness & Communications
COVID-19 Situation Update
July 8, 2021

Upcoming Webinar

Register HERE

To protect and improve the health and environment of all Kansans

On Wednesday, July 21, the Public Health Communications Collaborative will present a webinar called “COVID-19 and Return to In-Person Learning: Communicating with Constituents.” This webinar will take place at 12:00 noon Central time. The webinar will focus on effective messaging to communicate with families, teachers, and school officials in preparation for a safe and comfortable return to the classroom. Representing different local scenarios and constituencies, our three panelists will share insights and answer your questions. To register for this free webinar, click the link on your screen or visit https://trustforamericashealth.webex.com/mw3300/mywebex/default.do?nomenu=true&siteurl=trustforamericashealth&service=6&rnd=0.8075004991391943&main_url=https%3A%2F%2Ftrustforamericashealth.webex.com%2Fec3300%2Feventcenter%2Fevent%2EventAction.do%3FtheAction%3Ddetail%26%26%26EMK%3D4832534b0000000509387d18c95c7c8e53147e7da5fc9c15d9890a6e1fd2acb48f26e23192c0453b%26siteurl%3Dtrustforamericashealth%26confViewID%3D198392026881888944%26SourceId%3DphccTwitter%26encryptTicket%3DSDJTSwAAAAX6Pgem4336hiNWHDwQiGvAtAT5wEuLBHq_p4N1a-rVbw2%26.

Public Health On Call Podcast

Listen HERE

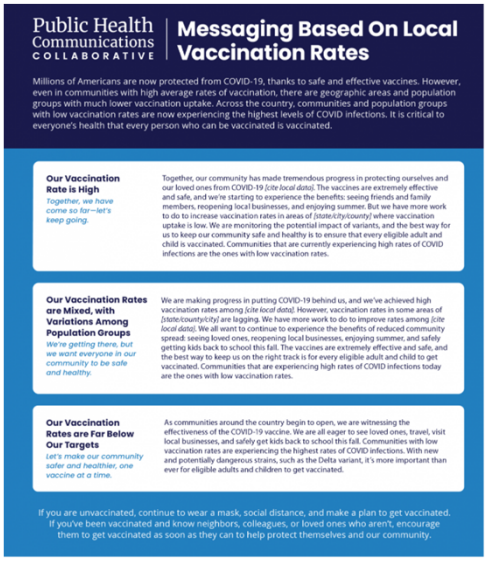
To protect and improve the health and environment of all Kansans

The latest Public Health On Call podcast from Johns Hopkins University is now available.

"COVID-19 Vaccines and Kids" - Youths 12 and older have been eligible for COVID-19 vaccines since March, but clinical trials are still ongoing for kids under 12. Dr. Kawsar Talaat, who led one of Pfizer's COVID-19 vaccine trials in adults, and Dr. Odis Johnson, executive director of the Johns Hopkins Center for Safe and Healthy Schools, talk about whether schools may require vaccines, the ethics of immunizing children when so many high-risk adults around the world don't have access to shots, risk factors for serious disease among children, and what is known currently about vaccine hesitancy among parents.
Link: https://johnshopkinssph.libsyn.com/342-covid-19-vaccines-and-children

You can listen to the podcast by clicking the link or wherever you listen to podcasts.

Vaccine Messaging Resource



Public Health Communications COLLABORATIVE | **Messaging Based On Local Vaccination Rates**

Millions of Americans are now protected from COVID-19, thanks to safe and effective vaccines. However, even in communities with high average rates of vaccination, there are geographic areas and population groups with much lower vaccination uptake. Across the country, communities and population groups with low vaccination rates are now experiencing the highest levels of COVID infections. It is critical to everyone's health that every person who can be vaccinated is vaccinated.

Our Vaccination Rate is High
Together, we have come so far—let's keep going.

Together, our community has made tremendous progress in protecting ourselves and our loved ones from COVID-19 *[cite local data]*. The vaccines are extremely effective and safe, and we're starting to experience the benefits: seeing friends and family members, reopening local businesses, and enjoying summer. But we have more work to do to increase vaccination rates in areas of *[state/city/county]* where vaccination uptake is low. We are monitoring the potential impact of variants, and the best way for us to keep our community safe and healthy is to ensure that every eligible adult and child is vaccinated. Communities that are currently experiencing high rates of COVID infections are the ones with low vaccination rates.

Our Vaccination Rates are Mixed, with Variations Among Population Groups
We're getting there, but we want everyone in our community to be safe and healthy.

We are making progress in putting COVID-19 behind us, and we've achieved high vaccination rates among *[cite local data]*. However, vaccination rates in some areas of *[state/county/city]* are lagging. We have more work to do to improve rates among *[cite local data]*. We all want to continue to experience the benefits of reduced community spread: seeing loved ones, reopening local businesses, enjoying summer, and safely getting kids back to school this fall. The vaccines are extremely effective and safe, and the best way to keep us on the right track is for every eligible adult and child to get vaccinated. Communities that are experiencing high rates of COVID infections today are the ones with low vaccination rates.

Our Vaccination Rates are Far Below Our Targets
Let's make our community safer and healthier, one vaccine at a time.

As communities around the country begin to open, we are witnessing the effectiveness of the COVID-19 vaccine. We are all eager to see loved ones, travel, visit local businesses, and safely get kids back to school this fall. Communities with low vaccination rates are experiencing the highest rates of COVID infections. With new and potentially dangerous strains, such as the Delta variant, it's more important than ever for eligible adults and children to get vaccinated.

If you are unvaccinated, continue to wear a mask, social distance, and make a plan to get vaccinated. If you've been vaccinated and know neighbors, colleagues, or loved ones who aren't, encourage them to get vaccinated as soon as they can to help protect themselves and our community.

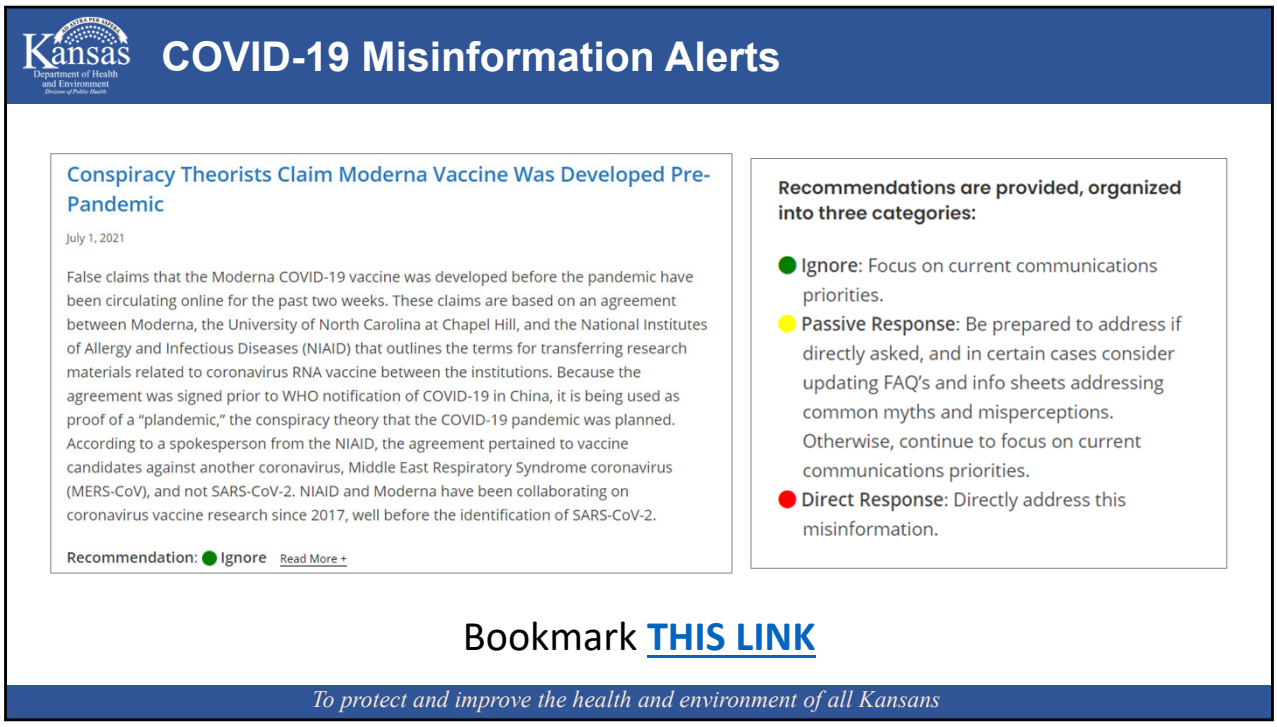
High vaccination rate:
Together we have come so far. Let's keep going!

Mixed/Variable vaccination rate:
We're getting there, but we want everyone in our community to be safe and healthy.

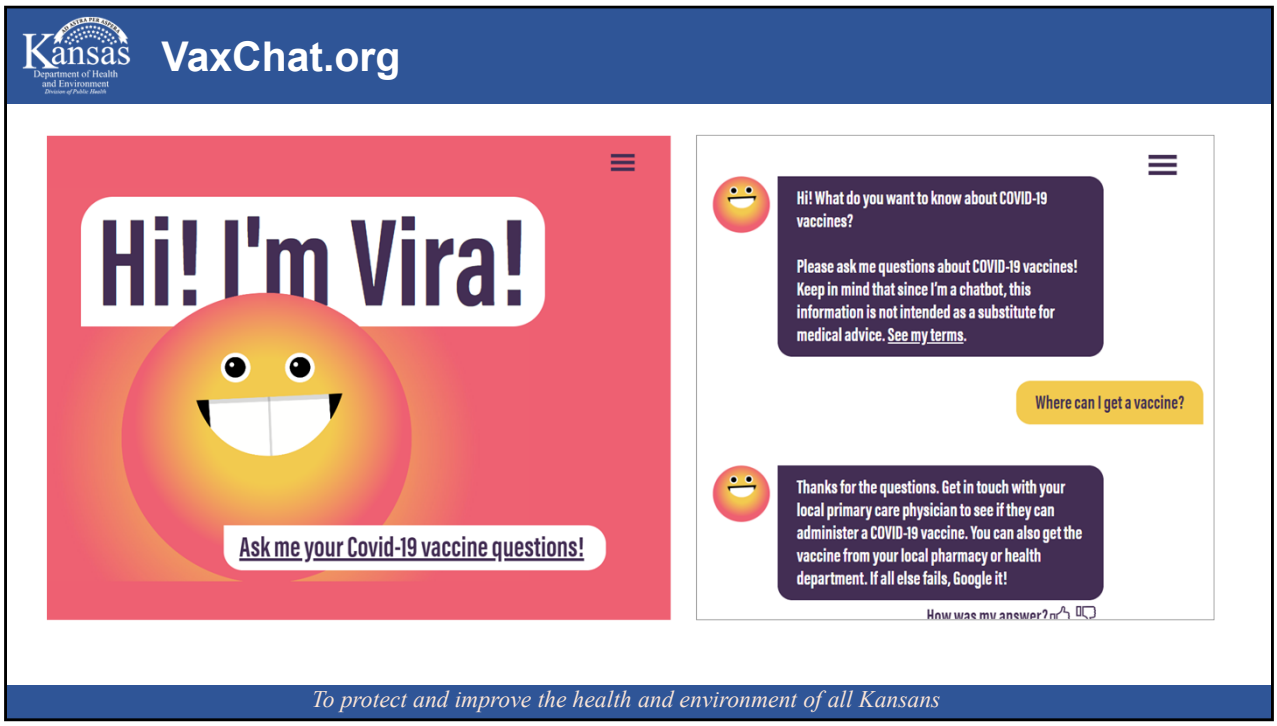
Vaccination rate is below our target:
Let's make our community safer and healthier one vaccine at a time.

To protect and improve the health and environment of all Kansans

Also from the Public Health Communications Collaborative, there is a new tool that can help you message vaccines to your community members based on local vaccination rates. You can see a screenshot of the messaging advice here, but a full-size PDF is available for download. Vaccine messaging for your community will vary depending on whether your community has a high vaccination rate, a low vaccination rate, or somewhere in between and this document can help. I've put a short summary of each category on this slide, but the document has so much more information, so I encourage you to download it. You can access it here: https://publichealthcollaborative.org/resources/graphic-messaging-based-on-local-vaccination-rates/



This is another great resource from the Public Health Communications Collaborative that you might find helpful. They have a website dedicated to tracking COVID-19 misinformation that is found online and in social media. The website summarizes the misinformation, discusses its origins, and gives recommendations on whether it is best to ignore the misinformation, be prepared for a passive response, or directly address the misinformation. There is also a section called "Tough Q&A" that can help you formulate an answer to some of the tough questions you might get about COVID-19. All of this is available on their website: https://publichealthcollaborative.org/misinformation-alerts/



This resource would be a great tool to share on social media or with technology-savvy friends and family.

Vira ("Vaccine Information Resource Assistant") is a chatbot developed by the International Vaccine Access Center at the Johns Hopkins Bloomberg School of Public Health with experts from the Bloomberg School's Department of International Health and Johns Hopkins Whiting School of Engineering.

Vira's knowledge base from Johns Hopkins vaccine scientists was developed with support from the COVID-19 Training Initiative, with funding from Bloomberg Philanthropies. VaxChat is powered by IBM Technology. You can visit VaxChat.org and as Vira questions about the COVID vaccine, and she'll provide you science-based answers. Vira is also a useful technology for the Bloomberg School of Public Health, as it monitors the questions asked and helps scientists develop answers to the questions that people have the most.

You can see on the right hand side of this screen I asked Vira a simple question and she provided me with an answer and an opportunity to give feedback about its answer. The questions and answers she gives are publicly available on a companion app called the COVID-19 Vaccine Resource Hub. There are also browsable FAQs on the VaxChat.org website.

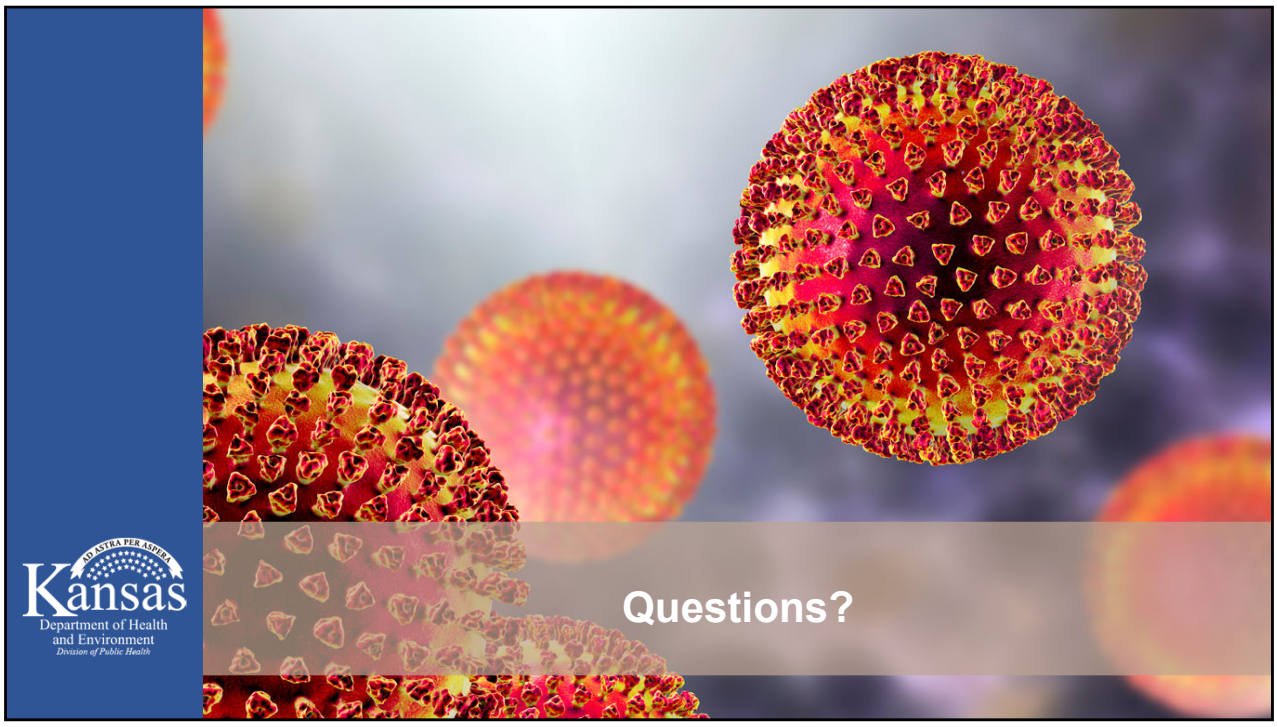
Upcoming Webinar

Click **HERE** to access

To protect and improve the health and environment of all Kansans

Rural telehealth adoption is growing significantly – particularly by connecting patients in their homes to a provider. While the growth is compelling, there is still untapped potential for rural hospitals to utilize telemedicine to drive down costs and improve the delivery of care within the acute care setting. This webinar will discuss ways to leverage tele-hospitalists to stabilize staffing, reduce recruiting costs, support advanced practice providers, and positively impact sub-specialist care. The webinar is hosted by the National Rural Health Association on Wednesday, July 14 at noon CT.

To register: https://register.gotowebinar.com/register/5710471284127098126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Department of Health and Environment
Division of Public Health
Questions?